BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

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| In the Matter of the Accusation Against: | ) | |
| HAGOS HABTEZGHI, M.D. | ) | Case No. 18-2009-201049 |
| Physician's and Surgeon's Certificate No. C 41500 | ) | |
| Respondent. | ) | |

## DECISION AND ORDER

The attached Stipulated Settlement and Disciplinary Order is hereby adopted by the Medical Board of California, Department of Consumer Affairs, State of California, as its Decision in this matter.

This Decision shall become effective at 5:00 p.m. on August 23, 2013.

IT IS SO ORDERED July 26, 2013.

MEDICAL BOARD OF CALIFORNIA

By: _____
Barbara Yaroslavsky, Chair
Panel A

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Acting Senior Assistant Attorney General
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*Attorneys for Complainant*

**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
**DEPARTMENT OF CONSUMER AFFAIRS**
**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**HAGOS HABTEZGHI, M.D.**<br><br>**3334 Heatherfield Drive,**<br>**Hacienda Heights, CA 91745**<br><br>**Physician's and Surgeon's Certificate**<br>**No. C 41500**<br><br>Respondent. | Case No. 18-2009-201049<br><br>OAH No. 2012080710<br><br>**STIPULATED SETTLEMENT AND DISCIPLINARY ORDER** |

In the interest of a prompt and speedy settlement of this matter, consistent with the public interest and the responsibility of the Medical Board of California (Board) of the Department of Consumer Affairs, the parties hereby agree to the following Stipulated Settlement and Disciplinary Order which will be submitted to the Board for approval and adoption as the final disposition of the Accusation.

PARTIES

1. Linda K. Whitney (Complainant) is the Executive Director of the Board. She brought this action solely in her official capacity and is represented in this matter by Kamala D. Harris, Attorney General of the State of California, by Chris Leong, Deputy Attorney General.

2. Respondent Hagos Habtezghi, M.D. (Respondent) is represented in this proceeding by attorney John Dratz, Jr, whose address is: John Dratz, Jr., 1400 South Grand Ave., Suite 701 Los Angeles, CA 90015.

3. On or about July 30, 1984, the Board issued Physician's and Surgeon's Certificate No. C 41500 to Respondent. The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought in Accusation No. 18-2009-201049 and will expire on September 30, 2013, unless renewed.

## JURISDICTION

4. Accusation No. 18-2009-201049 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on June 29, 2012. Respondent timely filed his Notice of Defense contesting the Accusation.

5. A copy of Accusation No. 18-2009-201049 is attached as Exhibit A and is incorporated herein by reference.

## ADVISEMENT AND WAIVERS

6. Respondent has carefully read, fully discussed with counsel, and understands the charges and allegations in Accusation No. 18-2009-201049. Respondent has also carefully read, fully discussed with counsel, and understands the effects of this Stipulated Settlement and Disciplinary Order.

7. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

8. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

## CULPABILITY

9. Respondent understands and agrees that the charges and allegations in Accusation No. 18-2009-201049, if proven at a hearing, constitute cause for imposing discipline upon his Physician's and Surgeon's Certificate.

10. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation, and that Respondent hereby gives up his right to contest those charges.

11. Respondent agrees that his Physician's and Surgeon's Certificate is subject to discipline and he agrees to be bound by the Board's probationary terms as set forth in the Disciplinary Order below.

12. Respondent agrees that if he ever petitions for early termination or modification of probation, or if the Board ever petitions for revocation of probation, all of the charges and allegations contained in Accusation 18-2009-201049 shall be deemed true, correct and fully admitted by Respondent for purposes of that proceeding or any other licensing proceeding involving respondent in the State of California.

## CONTINGENCY

13. This stipulation shall be subject to approval by the Medical Board of California. Respondent understands and agrees that counsel for Complainant and the staff of the Medical Board of California may communicate directly with the Board regarding this stipulation and settlement, without notice to or participation by Respondent or his counsel. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Settlement and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

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14. The parties understand and agree that facsimile copies of this Stipulated Settlement and Disciplinary Order, including facsimile signatures thereto, shall have the same force and effect as the originals.

15. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Disciplinary Order:

**DISCIPLINARY ORDER**

IT IS HEREBY ORDERED that Physician's and Surgeon's Certificate No. C 41500 issued to Respondent Hagos Habtezghi, M.D. (Respondent) is revoked. However, the revocation is stayed and Respondent is placed on probation for four (4) years on the following terms and conditions.

1. CONTROLLED SUBSTANCES- MAINTAIN RECORDS AND ACCESS TO RECORDS AND INVENTORIES. Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by Respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

2. PRESCRIBING PRACTICES COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in prescribing practices equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents

that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

3. MEDICAL RECORD KEEPING COURSE. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a course in medical record keeping equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program), approved in advance by the Board or its designee. Respondent shall provide the program with any information and documents that the Program may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after Respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have

been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

4. CLINICAL TRAINING PROGRAM. Within 60 calendar days of the effective date of this Decision, Respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after Respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of Respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to Respondent's area of practice in which Respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which Respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on Respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, treatment for any medical condition, treatment for any psychological condition, or anything else affecting Respondent's practice of medicine. Respondent shall comply with Program recommendations.

At the completion of any additional educational or clinical training, Respondent shall submit to and pass an examination. Determination as to whether Respondent successfully completed the examination or successfully completed the program is solely within the program's jurisdiction.

If Respondent fails to enroll, participate in, or successfully complete the clinical training program within the designated time period, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The Respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical training program have been completed. If the Respondent did not successfully complete the clinical training program, the Respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.

5. EDUCATION COURSE. Within 60 calendar days of the first anniversary of the effective date of this Decision, and on an annual basis thereafter, Respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge in pain management, and shall be Category I certified. The educational program(s) or course(s) shall be at Respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test Respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

6. NOTIFICATION. Within seven (7) days of the effective date of this Decision, the Respondent shall provide a true copy of this Decision and Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to Respondent, at any other facility where Respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to Respondent. Respondent shall submit proof of compliance to the Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

7. SUPERVISION OF PHYSICIAN ASSISTANTS. During probation, Respondent is prohibited from supervising physician assistants.

8. OBEY ALL LAWS. Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

9. QUARTERLY DECLARATIONS. Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation.

Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

10. GENERAL PROBATION REQUIREMENTS.

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes

Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021(b).

Place of Practice

Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal

Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event Respondent should leave the State of California to reside or to practice Respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

11. INTERVIEW WITH THE BOARD OR ITS DESIGNEE. Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

12. NON-PRACTICE WHILE ON PROBATION. Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of Respondent's return to practice. Non-practice is defined as any period of time Respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event Respondent's period of non-practice while on probation exceeds 18 calendar months, Respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve Respondent of the responsibility to comply with the

probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

13. COMPLETION OF PROBATION. Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, Respondent's certificate shall be fully restored.

14. VIOLATION OF PROBATION. Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

15. LICENSE SURRENDER. Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, Respondent may request to surrender his or her license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

16. PROBATION MONITORING COSTS. Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

## ACCEPTANCE

I have carefully read the above Stipulated Settlement and Disciplinary Order and have fully discussed it with my attorney, John Dratz, Jr. I understand the stipulation and the effect it will have on my Physician's and Surgeon's Certificate. I enter into this Stipulated Settlement and Disciplinary Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Board.

DATED: May 8th 2013

HAGOS HABTEZGHI, M.D.
Respondent

I have read and fully discussed with Respondent Hagos Habtezghi, M.D. the terms and conditions and other matters contained in the above Stipulated Settlement and Disciplinary Order. I approve its form and content.

DATED: May 8, 2013

JOHN DRATZ, JR
Attorney for Respondent

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ENDORSEMENT

The foregoing Stipulated Settlement and Disciplinary Order is hereby respectfully submitted for consideration by the Medical Board of California of the Department of Consumer Affairs.

Dated: May 9, 2013

Respectfully submitted,

KAMALA D. HARRIS
Attorney General of California
E. A. JONES III
Acting Senior Assistant Attorney General

CHRIS LEONG
Deputy Attorney General
*Attorneys for Complainant*

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# Exhibit A

**Accusation No. 18-2009-201049**

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**BEFORE THE**
**MEDICAL BOARD OF CALIFORNIA**
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**STATE OF CALIFORNIA**

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| In the Matter of the Accusation Against:<br><br>**HAGOS HABTEZGHI, M.D.**<br>**3334 S. Heatherfield Drive**<br>**Hacienda Heights, California 91745**<br><br>**Physician's and Surgeon's Certificate No. C 41500**<br><br>Respondent. | Case No. 18-2009-201049<br><br>**A C C U S A T I O N** |

Complainant alleges:

PARTIES

1. Linda K. Whitney (Complainant) brings this Accusation solely in her official capacity as the Executive Director of the Medical Board of California (Board).

2. On or about July 30, 1984, the Board issued Physician's and Surgeon's Certificate Number C 41500 to Hagos Habtezghi, M.D. (Respondent). The Physician's and Surgeon's Certificate was in full force and effect at all times relevant to the charges brought herein and will expire on September 30, 2013, unless renewed.

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## JURISDICTION

3. This Accusation is brought before the Board under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2227 of the Code provides that a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended for a period not to exceed one year, placed on probation and required to pay the costs of probation monitoring, or such other action taken in relation to discipline as the Board deems proper.

5. Section 2234 of the Code states:

"The Division of Medical Quality[1] shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

"(a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter [Chapter 5, the Medical Practice Act].

"(b) Gross negligence.

"(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.

"(1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

"(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the

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[1] California Business and Professions Code section 2002, as amended and effective January 1, 2008, provides that, unless otherwise expressly provided, the term "board" as used in the State Medical Practice Act (Cal. Bus. & Prof. Code, §§ 2000, et seq.) means the "Medical Board of California," and references to the "Division of Medical Quality" and "Division of Licensing" in the Act or any other provision of law shall be deemed to refer to the Board.

applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

"(d) Incompetence.

"(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

"(f) Any action or conduct which would have warranted the denial of a certificate."

6. Section 2266 of the Code states: "The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct."

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

7. Respondent is subject to disciplinary action under Code section 2234, subdivision (c), in that he committed repeated negligent acts in the care and treatment of his patients. The circumstances are as follows:

**Patient J.M.**

8. Patient J.M., a thirty-one year-old male, saw Respondent from February 16, 2005, until about April 5, 2010. Respondent treated the patient for hypertension, asthma, low back pain, degenerative joint disease of the lumbar spine, hyperlipidemia, and abdominal pain. A typical visit consisted of a "Chief Complaint/ Reason for Visit" recorded by the medical assistant, with zero to two handwritten lines of history written by Respondent. The initial intake history included a patient questionnaire and a chronic pain grading scale. There was no documentation of prior treatment for back pain. Throughout the next five years, Respondent did not document any history regarding the patient's complaints of pain, including functional ability, severity of the pain, or improvement/worsening of the pain. Respondent routinely prescribed Aspirin with Codeine and subsequently Tylenol with Codeine. Some of the dates the Tylenol with Codeine No. 3, (for 45 pills) prescriptions were filled were as follows: June 10, 2006; September 14, 2006; October 11, 2006; November 29, 2006; January 17, 2007; February 16, 2007; March 16, 2007; April 11, 2007; May 8, 2007; June 5, 2007; July 6, 2007; August 2, 2007; September 4,

2007; October 12, 2007; November 8, 2007; December 4, 2007; January 8, 2008; February 4, 2008; March 6, 2008; April 4, 2008; May 1, 2008; June 2, 2008; July 2, 2008; August 4, 2008; September 2, 2008; October 2, 2008; November 4, 2008; December 3, 2008; January 6, 2009; March 3, 2009; April 2, 2009; May 4, 2009; June 2, 2009; July 7, 2009: April 4, 2011; May 2, 2011; June 2, 2011; July 5, 2011; August 2, 2011; January 19, 2012; February 16, 2012; and February 27, 2012. Respondent did not document that he provided informed consent to the patient for chronic use of narcotics. Respondent did not document the record that he monitored and assessed the patient's pain condition. Respondent did not monitor his use of narcotic medications or reassess the effectiveness of treatment or the patient's need for narcotic medications. There was no justification in the records for his continued treatment with opiods. No other diagnostic workup or significant treatment was noted. Respondent did not develop a treatment plan to manage the patient's pain, such as attempts to wean the patient off the narcotic prescriptions, recognition of the long-term requirements for narcotics, or referrals for pain management, physical therapy or other modalities to address the patient's pain.

9. Respondent did not adequately control the patient's blood pressure. Respondent prescribed Lotrel and Micardis to the patient who continued to have very high systolic and diastolic pressures as follows: on September 14, 2006, his blood pressure was 152/99; on January 17, 2007, it was 162/100; on April 11, 2007, it was 154/104; on January 8, 2008, it was 165/111; on April 4, 2008, it was 159/102; on July 2, 2008, it was 179/114 and 182/110; on October 2, 2008, it was 178/106; on February 4, 2009, it was 154/84; on April 4, 2009, it was 150/93; on April 30, 2009, it was 175/100; on November 2, 2009, it was 164/91; and on February 8, 2010, it was 147/95. Respondent's inadequate treatment of the patient's blood pressure placed the patient at risk for heart damage, potential congestive heart failure, and renal damage.

10. On January 8, 2008, the patient's urinalysis indicated 1+ protein, and on February 3, 2010, the urinalysis indicated 2+ protein. Respondent did not address or evaluate the patient's proteinuria, a possible indication of kidney disease. Respondent did not refer the patient for a consultation with a Nephrology specialist.

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11. Respondent was repeatedly negligent in the care and treatment of Patient J.M. as follows:

(a) Respondent failed to monitor the use of, and reassess the need for, narcotic medications while treating a patient with chronic persistent pain.

(b) He failed to provide informed consent to the patient for chronic use of narcotics.

(c) He failed to attempt to wean the patient off of controlled substances, refer the patient to a specialist, or offer other modalities to address the pain.

(d) Respondent failed to document subsequent histories related to assessment of the patient's need for continued use of narcotic medications.

(e) Respondent failed to adequately control the patient's blood pressure which placed the patient at risk for heart damage, potential congestive heart failure, and renal damage.

(f) Respondent failed to address or evaluate the patient's proteinuria, which was a possible indication of kidney disease.

(g) Respondent failed to refer the patient for consultation with a nephrology specialist.

**Patient A.W.**

12. Patient A. W., a forty-nine year-old female, saw Respondent from September 26, 2005, until about October 14, 2010. Respondent treated the patient for low back pain, headache, urinary incontinence, and menopausal symptoms. A typical visit consisted of a "Chief Complaint/ Reason for Visit" recorded by the medical assistant with zero to two handwritten lines of history written by Respondent. On multiple visits, respondent did not document a history related to the patient's complaints of pain. Respondent routinely prescribed Tylenol with Codeine No. 3, (for 45 pills). Some of the dates these prescriptions were filled were as follows: September 26, 2005; October 26, 2005; November 28, 2005; February 27, 2006; May 12, 2006; August 16, 2006; September 14, 2006; October 30, 2006; November 14, 2006; December 12, 2006; January 8, 2007; January 24, 2007; February 7, 2007; March 1, 2007; April 17, 2007; May 24, 2007; June 22, 2007; July 24, 2007; August 22, 2007; October 10, 2007; November 19, 2007;

December 19, 2007; January 17, 2008; February 14, 2008; March 17, 2008; April 17, 2008; May 15, 2008; June 13, 2008; July 14, 2008; August 16, 2008; September 22, 2008; October 20, 2008; November 19, 2008; December 16, 2008; February 9, 2009; March 12, 2009; April 13, 2009; May 11, 2009; June 8, 2009; and July 8, 2009. Respondent did not document that he provided informed consent to the patient for the narcotic prescriptions, or that he discussed the risks and benefits of treatment options. Respondent did not document in the record any prior use of pain medication by the patient. Respondent did not document any subsequent histories. He did not document that he monitored and assessed the patient's pain condition, or reviewed the patient's use of pain medication to justify continued treatment with opiods. No other diagnostic workup or significant treatment was noted. Respondent did not develop a treatment plan with goals to manage the patient's pain. Respondent did not attempt to wean the patient off narcotics or document why weaning was not possible. He did not refer the patient for physical therapy, or offer any other modalities to address the pain.

13. The patient's hepatitis serologies were positive on March 1, 2007, and January 3, 2009. The hepatitis serologies had been negative on October 26, 2005. There was no documentation in the record that Respondent discussed the diagnosis with the patient. There was no indication that he addressed the chronic use of acetaminophen or codeine in the presence of a change in hepatitis serology.

14. At her original visit, the patient's examination revealed that she was normotensive and on no medication, yet Respondent prescribed Clonidine .2 mg twice daily. He continued to treat the patient with Clonidine .2 mg twice daily for hypertension. The patient's blood pressure at times was as follows: 109/77 on October 26, 2005; 95/67 on November 28, 2005; 89/70 on February 27, 2006; 107/72 on May 12, 2006; 100/56 on May 15, 2008; 115/84 on May 11, 2009; and 112/81 on May 18, 2010. On February 27, 2006, when the patient's blood pressure was 89/70, Respondent prescribed #60 Clonidine .3 mg twice daily. The patient experienced dizziness and felt faint on August 15, 2008, yet Respondent did not discontinue the blood pressure medication.

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15. There is no evidence in the records that the patient had chronic bronchitis, asthma, or obstructive pulmonary disease, yet Respondent treated her with various inhalers, multiple treatments of antibiotics, and the cough syrup Phenergan with Codeine. He prescribed Albuterol on October 26, 2005; Albuterol and Phenergan with Codeine on November 28, 2005; Albuterol, Phenergan DM, and Amoxicillin on February 27, 2006; Albuterol, Phenergan with Codeine, and Amoxicillin on May 12, 2006; Xopenex and Phenergan with Codeine on March 1, 2007; Azmacort, Phenergan DM and Cephalexin on August 22, 2007; Xopenex and Phenergan with Codeine on August 15, 2008; Xopenex and Phenergan DM on May 11, 2009; and Erythromycin and Symbicort on May 18, 2010.

16. On September 26, 2005, Respondent noted that the patient was allergic to penicillin. He prescribed Amoxicillin on February 27, 2006, and on May 12, 2006. On June 13, 2008, Respondent noted the patient had an odor of alcohol, but recommended no counseling, treatment or C.A.G.E. analysis to detect potential alcohol dependence. On April 19, 2010, the laboratory results of a PAP smear indicated the patient had trichomonas, but no treatment was mentioned in the record. Multiple progress notes were essentially unchanged from visit to visit.

17. Respondent was repeatedly negligent in the care and treatment of Patient A.W. as follows:

(a) Respondent failed to document in the record any prior use of pain medication by the patient.

(b) Respondent failed to document that he provided informed consent to the patient for the narcotic prescriptions.

(c) Respondent failed to document any subsequent histories related to the patient's complaints of pain.

(d) He failed to re-assess the patient's need for continuing use of narcotic medications.

(e) Respondent failed to wean the patient off of controlled substances.

(f) Respondent failed to address the diagnosis of Hepatitis B.

(g) Respondent failed to discontinue the blood pressure medication when the patient developed symptoms of dizziness and feeling faint.

(h) Respondent prescribed bronchodilator inhalers, antibiotics, and cough syrup without a diagnosis of chronic bronchitis, asthma, or upper respiratory infections.

(i) Respondent prescribed Amoxicillin to a patient who was allergic to penicillin.

(j) He failed to recommend counseling to a patient with a potential alcohol problem.

(k) He failed to provide treatment when the laboratory results indicated the patient had trichomonas.

(l) Multiple progress notes were essentially unchanged from visit to visit.

**Patient B.W.**

18. Patient B. W., a fifty year-old female, saw Respondent from June 22, 2004, until about November 2, 2009. Respondent treated the patient for hypertension, cardiovascular disease, right-sided paralysis, bronchial asthma, low back pain, and degenerative arthritis. A typical visit consisted of a "Chief Complaint/ Reason for Visit" recorded by the medical assistant, with zero to two handwritten lines of history written by Respondent. There is no documentation of any prior use of pain medications. Respondent routinely prescribed Tylenol with Codeine No. 3, (for 45 pills). Some of the dates these prescriptions were filled were as follows: January 1, 2006; June 1, 2006; September 1, 2006; October 2, 2006; November 1, 2006; December 1, 2006; January 2, 2007; February 1, 2007; March 1, 2007; May 1, 2007; June 1, 2007; July 2, 2007; August 1, 2007; September 4, 2007; October 1, 2007; November 1, 2007; December 3, 2007; January 2, 2008; February 1, 2008; March 3, 2008; April 1, 2008; May 1, 2008; July 1, 2008; August 1, 2008; September 2, 2008; October 1, 2008; November 3, 2008; December 2, 2008; January 6, 2009; March 2, 2009; April 1, 2009; May 1, 2009; June 1, 2009; and July 1, 2009.

19. There is no documentation that Respondent provided the patient with informed consent for the narcotic prescriptions. Respondent did not reassess and properly treat the patient's chronic pain condition. Respondent did not describe the type of pain being treated, the goals of treatment, or the justification for using Tylenol with Codeine long-term. There was no documentation that Respondent referred the patient for physical therapy or offered other

modalities to address the pain. Respondent did not document a plan to manage the patient's long-term narcotic use through weaning, recognition of the long-term requirements for narcotics, or referrals. On several occasions, Respondent diagnosed the patient with bronchitis without proper documentation and inappropriately treated her with the steroid inhaler Advair, the bronchodilator inhaler Albuterol, and the cough syrup Phenergan with Codeine. On June 1, 2006, the patient's examination revealed normal lung functions and normal heart sounds. However, Respondent diagnosed the patient with bronchial asthma and treated her with Keflex, Tylenol with Codeine, and Phenergan with Codeine. There was no documentation of wheezing, bronchi or pulmonary sounds consistent with acute bronchitis. No pulse oximetry testing or chest x-rays were done.

20. Respondent was repeatedly negligent in the care and treatment of Patient B.W. as follows:

(a) Respondent failed to document that he provided informed consent to the patient for chronic use of narcotics.

(b) Respondent failed to attempt to wean the patient off of controlled substances.

(c) Respondent failed to provide additional treatment options for the patient.

(d) Respondent failed to describe the type of pain being treated, the goals of treatment, or the justification for using Tylenol with Codeine long term.

(e) Respondent failed to reassess the patient's chronic pain condition or reassess the goals of treatment.

(f) Respondent misdiagnosed and/or failed to keep accurate records when he treated the patient with steroid and bronchodilator inhalers, antibiotics, and Phenergan with Codeine cough syrup without clinical findings to support the need for these prescriptions.

**Patient C.C.**

21. Patient C.C., a fifty-seven year-old male, saw Respondent from January 20, 2005, until about November 18, 2010. At his initial visit, the patient complained of cough, cold, and back pain. Respondent performed a physical examination and assessed degenerative lumbosacral vertebral disease, chronic bronchitis, and impaired vision. He ordered a hepatitis panel and

referred the patient to an eye clinic. He prescribed Tylenol No. 3, Phenergan with Codeine, and Amoxicillin. When the patient returned two weeks later, he prescribed Celebrex, Phenergan DM, and Amoxicillin. Respondent did not document the patient's response to treatment with these medications. There is no indication in the record that Respondent discussed with the patient the laboratory results of positive findings of Hepatitis B and Hepatitis C. Respondent diagnosed the patient with chronic bronchitis, disc degeneration of the L/S spine, generalized anxiety disorder and insomnia, and prescribed Phenergan with Codeine, Tylenol No. 3, and Klonopin 2 mg. Respondent did not review and document the patient's response to treatment for anxiety with benzodiazepines or his response to cough suppressant therapy with Phenergan with Codeine. Respondent did not develop and record a treatment plan for the patient. He did not document the patient's failure to respond to the nonsteriodal anti-inflammatory medication Celebrex prescribed on January 20, 2005. Respondent routinely prescribed Tylenol with Codeine No. 3, (for 45 pills). Some of the dates these prescriptions were filled were as follows: August 23, 2006; September 18, 2006; October 13, 2006; November 15, 2006; December 13, 2006; January 16, 2007; February 13, 2007; March 13, 2007; April 12, 2007; May 11, 2007; June 12, 2007; July 11, 2007; August 7, 2007; September 6, 2007; October 8, 2007; November 5, 2007; January 9, 2008; February 11, 2008; March 7, 2008; April 9, 2008; May 6, 2008; June 10, 2008; July 7, 2008; August 5, 2008; September 8, 2008; December 1, 2008; January 8, 2009; March 3, 2009; April 6, 2009; May 11, 2009; June 9, 2009; July 8, 2009; March 21, 2011; April 20, 2011; May 19, 2011; June 17, 2011; July 14, 2011; August 12, 2011; and September 6, 2011.

22. There were findings of elevated liver function tests on January 20, 2005; and April 6, 2009; chronic cough on January 20, 2005; March 15, 2005; June 14, 2005; April 9, 2008; and April 22, 2010; and hypertension on September 13, 2005 (162/100); April 9, 2008 (159/81); and April 6, 2009 (150/81). Respondent did not justify the use of Tylenol with Codeine long-term. He did not attempt to wean the patient off of pain medications. Respondent did not adjust therapy, begin a diagnostic workup, or obtain any specialty consultations. He did not recommend a colonoscopy as part of cancer screening, or recommend any vaccinations for flu, pneumonia, tetanus booster, and herpes zoster. Respondent did not adequately describe the medical condition

of the patient. Respondent did not adequately describe the rationale for treatment and medical recommendations.

23. Respondent was repeatedly negligent in the care and treatment of Patient C.C. as follows:

(a) Respondent failed to review and document the patient's response to treatment for anxiety with benzodiazepines, or his response to cough suppressant therapy with Phenergan with Codeine.

(b) He failed to document the patient's failure to respond to the nonsteriodal anti-inflammatory medication Celebrex.

(c) Respondent failed to develop and record a treatment plan for the patient.

(d) Respondent failed to justify the use of Tylenol with Codeine long-term.

(e) He failed to wean the patient off of pain medications.

(f) Respondent failed to adjust therapy, begin a diagnostic workup, or obtain any specialty consultations when he obtained positive findings of elevated liver function tests, chronic cough and hypertension.

(g) He failed to recommend a colonoscopy as part of cancer screening, or recommend any vaccinations for flu, pneumonia, tetanus booster, and herpes zoster.

(h) He failed to adequately describe the medical condition of the patient.

(i) Respondent failed to adequately describe the rationale for treatment and medical recommendations.

**Patient R.G.**

24. Patient R.G., a fifty-five year old male, saw Respondent from April 21, 2005, until about October 16, 2008. At his initial visit, the patient complained of back and nerve pain, and reported that he had a prior stroke, hepatitis, hypertension, and back problems. The patient was on Tylenol No. 3 prior to seeing Respondent. Respondent diagnosed the patient with lumbar sacral low back pain, abdominal pain due to a gunshot wound, anxiety disorder, post traumatic stress disorder, and cerebral vascular accident (stroke) with left-sided weakness. Respondent ordered laboratory tests, and prescribed Tylenol No. 3, (for 45 pills) per month, Valium 10 mg

#60, Phenergan DM, and anti-hypertensive medications. On subsequent visits, Respondent refilled the medications including Tylenol No. 3, and Phenergan with Codeine, including May 24, 2007; November 27, 2007; and March 3, 2008. Respondent also documented on subsequent visits that the patient had the mental disorder schizophrenia.

25. Respondent did not develop and document a treatment plan with goals to manage the patient's pain. Respondent did not discuss the risks and benefits of treatment options, including the use of controlled substances. Respondent did not attempt to wean the patient off narcotic medications, or document why that was not possible. Respondent did not refer the patient for physical therapy, pain management, or psychiatric care.

26. Respondent did not justify in the patient's progress notes the use of controlled medications and opiates. Progress notes for August 6, 2005; and August 21, 2007 were missing. Progress notes for June 24, 2005; July 24, 2005; October 25, 2007; November 28, 2007; February 5, 2008; May 8, 2008; May 30, 2008; July 16, 2008; August 6, 2008; and November 21, 2008; contained only one short sentence regarding medication refills. Progress notes for April 21, 2005; May 19, 2005; August 17, 2005; May 24, 2007; July 23, 2007; September 28, 2007; December 28, 2007; March 3, 2008; June 13, 2008; September 8, 2008; and October 16, 2008; were short paragraphs with inadequate descriptions of chronic pain and assessment of medication benefit. There was no assessment of universal pain precautions, and no re-assessment of the patient's pain to justify continued use of narcotic analgesics.

27. Respondent was repeatedly negligent in the care and treatment of Patient R.G. as follows:

(a) Respondent failed to develop and document a treatment plan with goals to manage the patient's pain.

(b) Respondent failed to discuss the risks and benefits of treatment options, including the use of controlled substances.

(c) Respondent failed to wean the patient off narcotic medications, or document why that was not possible.

(d) Respondent failed to refer the patient for physical therapy, pain management, or psychiatric care.

(e) Respondent's progress notes were sparse and inadequate to justify the continued use of controlled medications and opiates.

**Patient N.H.**

28. Patient N.H., a fifty-two year-old female, saw Respondent from August 25, 2004, until about October 1, 2010. At her initial visit, the patient complained of headaches, and reported a history of hypertension and seizure disorder. Respondent diagnosed the patient with chronic headaches without concussion, epilepsy, and hypertension. Respondent diagnosed the patient with substance dependence on November 1, 2006; December 4, 2006; March 1, 2007; and December 3, 2007. On September 7, 2005; August 2, 2007; December 3, 2007; May 6, 2008; September 3, 2008; June 1, 2009; September 1, 2009; and March 1, 2010, Respondent's notes indicated that the patient appeared intoxicated or there was continued use of alcohol. Subsequent diagnoses include chronic low back pain on January 5, 2009; March 2, 2009; June 1, 2009; and May 3, 2010.

29. Respondent did not document the patient's history related to prior treatments for headaches, response to treatment, or history, status or nature of the patient's chronic substance dependence. Respondent did not indicate the goals of treatment or any attempt to use non-narcotic medications for the treatment of headaches. Respondent prescribed Tylenol with Codeine No. 3, (for 45 pills), monthly from August 2006 through July 2009. Some of the dates these prescriptions were filled were as follows: August 2, 2006; September 5, 2006; October 2, 2006; November 1, 2006; December 4, 2006; January 2, 2007; February 5, 2007; March 1, 2007; May 2, 2007; June 4, 2007; July 2, 2007; August 2, 2007; October 4, 2007; November 1, 2007; December 3, 2007; January 2, 2008; February 1, 2008; March 3, 2008; April 1, 2008; May 6, 2008; July 1, 2008; August 1, 2008; September 3, 2008; November 5, 2008; December 2, 2008; January 5, 2009; March 2, 2009; April 1, 2009; May 1, 2009; June 1, 2009; and July 1, 2009.

30. When the patient appeared intoxicated with slurred speech on several visits, Respondent did not order a Dilantin level, and he did not document a differential diagnosis of

Dilantin toxicity or post-ictal state. He also did not check urine drug and alcohol levels. Although Respondent noted the smell of alcohol, slurred speech, and substance use disorder in the patient's record multiple times, he did not discuss possible addiction, offer treatment, recommendations, or alter therapy. Despite the patient's intoxicated appearance, Respondent prescribed refills for controlled substances, including Tylenol No. 3 and Dalmane.

31. Respondent did not refer the patient to a neurologist for further evaluation of the headaches in a patient requiring ongoing narcotics and a history of head trauma. Respondent did not monitor the serum Dilantin levels in the patient although the patient suffered from seizure disorder.

32. With respect to the patient's complaints of pain, there is no documentation of consultations or referrals to pain management, orthopedic surgery, physical therapy, or any other treatment methods. There was no medical indication or justification in the record for the continued monthly prescribing of Tylenol with Codeine No. 3. Respondent did not provide ongoing evaluation, review of treatment, or assessment of the patient's pain. He did not consider opiate dependence when treating her chronic pain.

33. The patient's blood pressure was 205/122 on March 10, 2006; 194/112 on June 4, 2007; 172/96 on January 5, 2009; 172/85 on June 1, 2009; 162/83 on September 1, 2009; and 151/84 on January 4, 2010. There was no indication in the record that Respondent notified the patient of these elevated blood pressure levels. Respondent did not evaluate and treat the patient's elevated blood pressure. Respondent did not refer the patient to a consultant.

34. The patient presented with a red, swollen, and tender ankle on May 3, 2010. There was no history, examination, diagnosis or treatment of this condition in the record. He did not ask the patient if she had fallen. No x-rays were taken. Respondent did not refer the patient to the emergency room or to a consultant.

35. Respondent was repeatedly negligent in the care and treatment of Patient N.H. as follows:

(a) Respondent failed to document the patient's history related to prior treatments for headaches, response to treatment, and the patient's chronic substance dependence.

(b) Respondent failed to document goals of treatment or any attempt to use non-narcotic medications to treat headaches.

(c) On several visits when the patient appeared intoxicated, Respondent failed to order a Dilantin level or document a differential diagnosis of Dilantin toxicity or post-ictal state.

(d) Despite the patient's intoxicated appearance, Respondent prescribed refills for controlled substances, including Tylenol No. 3 and Dalmane.

(e) Respondent failed to document the status or nature of the patient's substance dependence.

(f) Respondent failed to consider a neurological referral for the patient's headaches, or any referrals to pain management, orthopedic surgery, or physical therapy.

(g) Respondent failed to provide medical indication or justification for the continuous monthly prescribing of Tylenol with Codeine No. 3.

(h) Respondent failed to provide ongoing evaluation, review of treatment, or assessment of the patient's pain.

(i) He prescribed Tylenol with Codeine even when the patient had alcohol on her breath and appeared intoxicated.

(j) Respondent failed to address the patient's drug and alcohol use.

(k) He failed to discuss with the patient her history of addiction and alcohol use when he treated her with addictive medication.

(l) He failed to consider opiate dependence when treating her chronic pain.

(m) Respondent failed to discuss with the patient possible addiction, offer treatment, recommendations, or alter therapy.

(n) Respondent failed to monitor the serum Dilantin levels in a patient who suffered from seizure disorder.

(o) Respondent also failed to check urine drug and alcohol levels.

(p) Respondent failed to notify the patient of her elevated blood pressure levels.

(q) Respondent failed to evaluate and treat the patient's elevated blood pressure.

(r) Respondent failed to refer the patient to a consultant or another physician willing to treat and evaluate the patient, i.e. Nephrology specialist.

(s) Respondent failed to document in the record a history, examination, diagnosis or treatment when the patient presented with a red, swollen, and tender ankle on May 3, 2010; and failed to refer the patient to the emergency room or to a consultant for this condition.

**Patient D.B.**

36. Patient D.B., a fifty-one year-old female, saw Respondent from December 15, 2005, until about May 2010. At her initial visit, the patient complained of pain in her legs, back, and hips, as well as cough and spasms. She was taking Tylenol No. 3 and Phenergan. Respondent noted substance dependence, multiple joint pains, and polyarthritis/degenerative joint disease. X-rays confirmed the patient had spondylosis of thoracic and lumbar spine, and right knee patellar tendonitis. Respondent diagnosed the patient with Hepatitis C, anxiety disorder/insomnia for which he prescribed Klonopin 2 mg #60, and chronic bronchitis for which he prescribed Phenergan with Codeine. Respondent did not document a history of prior pain treatments.

37. Between 2006 and 2010, Respondent prescribed Tylenol with Codeine on a long-term basis without noting a significant history of chronic pain. Some of the dates these prescriptions were filled were as follows: September 12, 2006; October 16, 2006; November 16, 2006; December 14, 2006; January 16, 2007; February 13, 2007; March 12, 2007; May 3, 2007; June 6, 2007; July 16, 2007; August 13, 2007; September 12, 2007; October 12, 2007; November 8, 2007; December 5, 2007; January 9, 2008; February 20, 2008; March 18, 2008; May 27, 2008; June 24, 2008; July 22, 2008; August 12, 2008; October 3, 2008; November 6, 2008; December 3, 2008; January 5, 2009; March 3, 2009; April 2, 2009; May 4, 2009; June 2, 2009; and July 7, 2009. There was no documentation in the record that Respondent followed pain management guidelines to justify ongoing treatment. The progress notes for fifteen visits from May 15, 2006, to February 9, 2010, were unchanged. Most progress notes were very short, and without significant explanation or description of medical problems. There were forty-seven records on five pages. Page one contained twelve notes refilling medications, page two contained

fourteen notes refilling medications, page three contained five notes refilling medications, page four contained nine notes refilling medications, and page five contained seven notes refilling medications. Respondent's records did not adequately describe the patient's pain issues or the justification for treatment.

38. Respondent was repeatedly negligent in the care and treatment of Patient D.B. as follows:

(a) Respondent failed to document the patient's history or prior pain treatments. Respondent prescribed Tylenol with Codeine while failing to document a significant history of chronic pain.

(b) Respondent failed to document that he followed pain management guidelines to justify ongoing treatment.

(c) Respondent failed to adequately describe the patient's pain issues, with most progress notes being very short and unchanged from visit to visit.

**Patient L.B.**

39. Patient L.B., a forty-four year-old female, saw Respondent from January 23, 2001, until about February 1, 2011. At her initial visit, the patient complained of chest pains and flu symptoms. On the patient's intake health history, there was no report of musculoskeletal pain. However, on a Chronic Pain Grading Scale, the patient rated her pain as 9 out of 10. Respondent's notes indicate chronic left mandibular dislocation, seizure disorder, peptic ulcer disease, chronic headaches, and generalized anxiety and insomnia. Respondent did not document any jaw tenderness. The information gathered on the patient intake form, chronic pain form and physical examination were not consistent. There was no history of prior evaluation and treatment for jaw pain. In a prior history and physical done by a different physician in 2002, the patient denies any joint pain and no jaw abnormalities are noted. Respondent prescribed Tylenol No. 3, Klonopin, Phenytoin, Clonidine, Dalmane and Nexium.

40. Respondent did not document in his notes the medical conditions referred to in the medical records from emergency room and hospital visits. Respondent did not document a history related to musculoskeletal pain for which he prescribed controlled substances. The only

documentations of pain history were statements noted by the medical assistant recording the chief complaint. Respondent did not document that he provided the patient with informed consent regarding treatment options for her chronic pain and use of controlled substances. He did not perform follow-up evaluations, monitoring of pain treatment, and did not follow pain management guidelines. Respondent did not identify a treatment plan to manage the patient's pain. There is no indication that Respondent attempted to use non-controlled substances for the patient's pain. Respondent did not provide referrals for treating the pain.

41. There were no significant written examinations. Respondent's medical records and progress notes do not adequately describe the medical problems and physical findings to justify the patient's use of controlled drugs and opioid analgesics. Respondent's records are unchanged from visit to visit. There was no assessment of treatment and progress.

42. Respondent prescribed Tylenol with Codeine on a long-term basis without noting a significant history of chronic pain. Some of the dates these prescriptions were filled were as follows: August 18, 2006; September 29, 2006; November 2, 2006; November 30, 2006; December 19, 2006; January 16, 2007; February 20, 2007; March 22, 2007; April 18, 2007; May 16, 2007; June 15, 2007; July 12, 2007; August 13, 2007; September 13, 2007; October 26, 2007; November 27, 2007; December 24, 2007; January 22, 2008; February 19, 2008; March 20, 2008; April 17, 2008; May 15, 2008; June 10, 2008; July 7, 2008; August 7, 2008; September 3, 2008; October 7, 2008; November 3, 2008; January 6, 2009; March 3, 2009; April 2, 2009; May 4, 2009; June 1, 2009; July 1, 2009; April 1, 2011; May 2, 2011; June 1, 2011; July 6, 2011; and August 3, 2011.

43. For her anxiety disorder, Respondent prescribed Clonazepam 2 mg #100 on February 2, 2007; July 16, 2007; October 3, 2007; November 5, 2007; January 7, 2008; February 1, 2008; March 3, 2008; May 1, 2008; July 2, 200; May 31, 2011; and October 31, 2011. In treating the patient's generalized anxiety disorder, there was no indication that Respondent attempted to change Clonazepam to a non-controlled substance such as a selective serotonin reuptake inhibitor. There is no indication that Respondent referred the patient for psychiatric care, or that he made any attempts to wean the patient off of Klonopin.

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44. Respondent was repeatedly negligent in the care and treatment of Patient L.B. as follows:

(a) Respondent failed to perform and document a medical history and physical examination of the patient, including history of prior evaluation and treatment of jaw pain.

(b) Respondent failed to document the patient's medical conditions referenced in emergency room and hospital visits.

(c) Respondent failed to document a history related to musculoskeletal pain for which he prescribed controlled substances.

(d) Respondent failed to document that he provided the patient with informed consent regarding treatment options for her chronic pain and use of controlled substances.

(e) Respondent failed to identify a treatment plan or provide referrals for treating the pain.

(f) Respondent failed to perform follow-up evaluations, monitor pain treatment, and follow pain management guidelines.

(g) He failed to document any significant written examinations.

(h) His medical records and progress notes failed to adequately describe the medical problems and physical findings to justify the patient's use of controlled drugs and opioid analgesics.

(i) Respondent failed to assess the patient's treatment and progress.

(j) Respondent failed to use non-controlled substances to manage the patient's pain and anxiety disorder.

(k) Respondent failed to refer the patient for psychiatric care or attempt to wean the patient off of Klonopin.

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**Patient K.A.**

45. Patient K.A., a forty-seven year-old female, saw Respondent from January 11, 2001, until about February 17, 2011. At her initial visit, the patient presented with complaints of pain and a history of cancer. Repeated visits indicate complaints of pain. It was also documented that the patient had a psychiatric disorder. Respondent prescribed Tylenol with Codeine on a long-term basis. Some of the dates these prescriptions were filled were as follows: September 14, 2006; December 8, 2006; January 2, 2007; February 2, 2007; March 1, 2007; May 1, 2007; June 12, 2007; July 16, 2007; September 4, 2007; October 3, 2007; November 5, 2007; December 6, 2007; January 7, 2008; February 1, 2008; March 3, 2008; May 1, 2008; September 10, 2008; July 2, 2009; May 31, 2011; July 25, 2011; and November 30, 2011. For her anxiety disorder, Respondent prescribed Clonazepam 2mg #100. These prescriptions were filled on February 2, 2007; July 16, 2007; October 3, 2007; November 5, 2007; January 7, 2008; February 1, 2008; March 3, 2008; May 1, 2008; July 2, 2009; May 31, 2011; and October 31, 2011.

46. Respondent did not obtain histories regarding the nature and quality of the pain. Respondent did not adequately describe the patient's chronic pain issues, pain generators or assessment of the pain. He did not document the treatment and management of the pain. There was no indication in the record that Respondent adequately monitored the patient's monthly use of Tylenol with Codeine No. 3 for pain. Respondent's progress notes and medical records were inadequate to justify long-term use of controlled medications and opiate analgesic drugs. Respondent did not document the patient's symptoms related to the diagnosis of generalized anxiety disorder.

47. Respondent diagnosed the patient with diabetes when there were no abnormal glucose or hemoglobin laboratory tests. Respondent did not refer the patient to an endocrinologist to determine if the diagnosis was accurate. The patient had a history of seizures, insomnia, anxiety, and schizophrenia. Respondent did not check her Phenobarbital level or her Dilantin level to ensure that acceptable doses were prescribed. The patient was on multiple benzodiazepines

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including Klonopin, Dalmane, and Valium, which placed her at risk for acute withdrawal and sudden seizure occurrence. Respondent did not refer the patient for a psychiatric consultation.

48. The patient had elevated thyroid stimulating hormone levels on March 1, 2007 (13.65), January 8, 2008 (8.47), and July 2, 2009 (8.06). There was no indication in the record that Respondent discussed this with the patient or increased Levoxyl. Also on March 1, 2007, the patient's urinalysis results indicated a urinary tract infection. On January 8, 2008, the patient had a urinary tract infection with 1014 white blood cells, 3+ leukocytes, and moderate bacteria. There was no indication in the record that the urinary tract infection was discussed with the patient or treated.

49. Respondent was repeatedly negligent in the care and treatment of Patient K.A. as follows:

(a) Respondent failed to obtain histories regarding the nature and quality of the pain. He failed to assess, treat, and manage the patient's pain.

(b) Respondent failed to adequately monitor the patient's monthly use of Tylenol with Codeine #3 for pain.

(c) Respondent's progress notes and medical records failed to justify long-term use of controlled medications and opiate analgesic drugs.

(d) Respondent's notes failed to document the symptoms related to the diagnosis of generalized anxiety disorder.

(e) Respondent diagnosed the patient with diabetes when there were no abnormal glucose or hemoglobin laboratory tests. Respondent failed to refer the patient to an endocrinologist.

(f) Respondent failed to refer a patient with a mental disorder and seizure disorder who was on multiple highly addictive controlled medications to a psychiatrist.

(g) Respondent failed to change the patient's medication when her laboratory results revealed elevated thyroid stimulating hormone levels. On at least two occasions,

(h) Respondent failed to discuss with the patient or treat her urinary tract infection.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate and Accurate Records)

50. Respondent is subject to disciplinary action under Code section 2266, in that he failed to maintain adequate and accurate records relating to the provision of services to his patients. The fact and circumstances alleged in the First Cause for Discipline are incorporated as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board issue a decision:

1. Revoking or suspending Physician's and Surgeon's Certificate Number C 41500 issued to Hagos Habtezghi, M.D.;

2. Revoking, suspending or denying approval of his authority to supervise physician assistants pursuant to section 3527 of the Code;

3. Ordering him to pay the Board the costs of probation monitoring, if he is placed on probation; and

4. Taking such other and further action as deemed necessary and proper.

DATED: June 29, 2012

LINDA K. WHITNEY
Executive Director
Medical Board of California
Department of Consumer Affairs
State of California
*Complainant*

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